PHYSICIAN STATE/COMMUNITY MATCHING
LOAN REPAYMENT PROGRAM APPLICATION

ND Department of Health
Division of Health Facilities
SFN 18571 (10-2002)

Dept. Use Only

File Number:

Telephone: 701.328.2894

Name of Physician				
Home Address	City	State	Zip Code	Home Phone
Office Address	City	State	Zip Code	Office Phone
I prefer to be contacted at ☐ Home ☐ Office ☐ Either				
Identify your specialty ☐ General Practice ☐ Family Practice ☐ General Surgery ☐ Internal Medicine ☐ Pediatrics ☐ Psychiatry ☐ OB/Gyn Other, please specify:				

TRAINING

Medical School	Year of Graduation
Internship	Year of Completion
Residency	Year of Completion
Post Graduate	Year of Completion

Certification Status

☐ NDBME ☐ FLEX ☐ ECFMG ☐ Other

Current Status

☐ Chief Resident (Circle year: 1 2 3 4 5)
☐ Resident (Circle year: 1 2 3 4 5)
☐ Medical Director (Circle year: 1 2 3 4 5)
☐ Practice ☐ Teaching ☐ Administration
☐ Other

State License	State	Year	License Number

Practice Experience	Location	Type	Years
Hospital Privileges	Location	Type	Years

OUTSTANDING MEDICAL EDUCATION LOANS

Lender/Address	Loan Number	Amount	Balance	Date Loan Must Be Paid

Are you in default on any loans? No ☐ Yes ☐ - identify loan and amount.

How much money are you requesting? (You may request no more than $40,000)

Name of North Dakota community where you will practice	Date you will be able to begin

Do you have a medical license in any state or country other than North Dakota? No ☐ Yes ☐ - specify.

Are you currently in litigation? No ☐ Yes ☐ - explain.

EMPLOYMENT HISTORY (List most recent employer first)

Employer	Address	Dates Employed

Do you accept Medicare assignment?	Do you accept Medicaid assignment?
Yes ☐ No ☐	Yes ☐ No ☐

1. Attach three letters of recommendation.
2. Attach a copy of your North Dakota medical license.
3. Attach a letter of support from the community you would like to serve.
4. Include the attached Community Participation Form (SFN 50557) signed by a community representative stating the community will pay fifty percent of your loan repayment amount in exchange for 4 (four) years of full-time medical services.

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a state/community matching physician loan repayment subject to the provisions of North Dakota Century Code Chapter 43-17.2 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health.

_____ _____
Signature Date

State of _____)
) ss
County of _____)

On this _____ day of _____, year _____, before me personally appeared _____ who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.

_____
Notary Public

(Seal)

My commission expires _____

Return the completed application to:

Department of Community Medicine
University of North Dakota
501 North Columbia Road
P.O. Box 9037
Grand Forks, ND 58202-9037

Grant Award No.	**CFDA No.**	North Dakota Department of Health 600 East Boulevard Ave-Dept. 301 Bismarck, ND 58505-0200 **NOTICE OF GRANT AWARD**
Budget Period From:	Through:	

Title of Project/Program:			**Health Dept. Grant Code:**
Grantee Name and Address: Contact Name: Telephone:		**North Dakota Department of Health Program Director:** Gary Garland Office of Community Assistance 600 E Boulevard Ave Dept 301 Bismarck ND 58505-0200 Telephone: (701) 328-4839	
Financial Information	**Health Dept. Share**	**Grantee Share Required** (Federal SLRP	**Total Project Costs**
Amount of Financial Assistance	$	$	$
Previous Funds Awarded		$	$
Total Funds Awarded to Date	$	$	$

All Grant Award payments are processed upon receipt of expenditure reports unless otherwise specified in Special Conditions.

Scope of Service: The grantee agrees to provide full-time service for a minimum of two years in the Community, identified in the application as approved by the Health Council; maintain licensure to practice in North Dakota; and accept Medicare and Medicaid patients as specified on the application form.

Special Conditions: Grantee must have practiced at least six months on full-time basis before any loan repayment may be made.

The loan repayment funds may not be used to satisfy other services obligations under similar programs.

If the grantee breaches the loan repayment program contract by failing to begin or failing to complete the obligated service, the grantee is liable for the total amount of any loan repayment funds received. Any damages must be paid to the Department within one year of the breach. Any amounts not paid within one year from the date of breach are subject to the collection process and may be recovered through deductions in Medicaid payments. Damages recoverable include all interest, costs and expenses incurred in collection, including attorney's fees if allowable under law.

Any financial obligation of the Department of Health arising out of this loan repayment contract and any obligation of the dentist that is conditioned thereon, is contingent on funds being appropriated by the legislature for loan repayment under North Dakota Century Code Chapter 43-28.1 and on Federal funds being awarded for the continuation of the State Loan Repayment Program (SLRP). If a participant receives a state/SLRP award, this award is subject to the terms and conditions incorporated either directly or by reference in the following: 45 CFR Part 74; 45 CFR Part 92, 42 U.S.C. 1320a – 7b(b). All federal penalties apply if the state/SLRP contract is breached.

Remarks:

This contract is not effective until fully executed by both parties.

Evidence of Grantee's Acceptance		**Evidence of Departmental Acceptance**	
Signature	Date	Signature	Date
Typed Name and Title of Authorized Representative		**Typed Name and Title of Authorized Representative** Arvy Smith, Deputy State Health Officer	
Signature	Date	Signature	Date
Typed Name and Title of Authorized Representative		**Typed Name and Title of Authorized Representative** **Gary S. Garland, Director** **Office of Community Assistance**	

SFN53771